A cross-national comparison of mental 'wellbeing' discourse between Indian and UK policy documents

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Abstract

Introduction: Poor mental health has been inextricably linked to societal factors such as stigma, poverty, unemployment, social discrimination, etc. This has been proposed by several mental health policies. However, the governance and the actual 'problems' behind the mental 'wellbeing' of individuals often get neglected and induce a political framework that controls the public behaviour and policymaking approach.

Aims and Research Questions: The aim of the research paper is to conduct a cross-national policy analysis on the concept of mental 'wellbeing' and how it gets 'problematized'. The research paper intends to highlight the neo liberalistic political framework and trace out what 'governance' controls the mental 'wellbeing' and the 'recovery' discourse.

Method: Bacchi's (2009) WPR methodology focuses on a specific set of questions which helps to determine the dormant 'problems' and the presuppositions underpinning those 'problems' in a policy (which were otherwise normalized). To conduct the analysis, two mental health policy documents were selected from India and the UK and analyzed through a critical discourse perspective.

Results: The analysis was conducted by identifying the 'governmentality' behind the problematization of mental wellbeing. Between India and the UK, the problematization of 'mental wellbeing' has been correspondingly defined as: 'deprivation' VS 'social exclusion' to poor mental wellbeing, pathologizing vs personalized (recovery mechanism), and socio-democratic vs neo-liberalistic governmentality.

Conclusion: The problematization of mental 'wellbeing' inherently implies towards the neo liberalistic/individualistic paradigm in the UK as compared to the socio-democratic/collectivistic paradigm in India.

Keywords: discourse, governmentality, neoliberalism, problematization

Journey: Mental Health Policies

The inception of a 'government policy' is largely driven by the subjective definition of 'problems'. Problems in this context imply the things that are considered problematic within a given cultural and/or historical setting (such as sexuality, fundamental rights, mental health, etc.) which perpetuate a discussion in public and hence pertain a considerable impact on the framing of policies (Bacchi, 2005; Bacchi, 2012). Policies that are supposed to 'shape' a society by introducing 'friendly' measures (Loranger et al., 1994) are inherently based on the 'social reality' in which these problems 'emerge', which itself has emerged across changing times through multiple heterogeneous practices (Bacchi, 2012). One such 'problem' is the construct of 'mental wellbeing', which is supposedly a "westernized influence" (Wondie & Abawa, 2019); the construct has witnessed drastic changes and has eventually come across as an acceptable and normalized concept in most South-Asian countries (Mooney et al., 2016). Especially, countries with a predominant non-western cultural ideology, have not completely accepted mental health illness as a legitimate form of 'illness' and thus refrain from 'treatment' through therapies and interventions, which in turn, has impacted the context in which policymakers perceive social problems and draft policy in response (Naveed et al., 2020). This 'critical reflexivity and social reality, in unison, control the discourse of policy and determine the specific 'problems' the policymakers aim to solve through these policies (Bletsas & Beasley, 2012, p. 22).

A globally accepted definition of mental health by the World Health Organization (2001, as cited Reddy, 2019) elicits that it is a state of well-being in which the individual is aware of their own abilities, has the potential to cope with primary stressors in life, can be productive, and is able to make a significant contribution to their community. However, mental 'wellbeing' is not as simplified as is stated in these 'widely accepted' definitions whilst making policies (Herrman & Jané-Llopis, 2012). A nation's status and the culturally accepted notion of mental 'wellbeing'are grown out of their own sensibilities, their environment, and their culture-induced

behaviour (Office of the Surgeon General (US), 2001). From an economic perspective, in India, mental 'wellbeing' has been a significant factor in the lives of the 'less privileged' population and particularly the ones who have undergone a 'societal deprivation' of amenities such as poverty, lower educational levels, lower household income, etc. (Reddy, 2019). Moreover, unemployment has been one of the contributing factors towards mental health difficulties and illnesses in both rural and urban populations (Fryer & Fagan, 2003). Policies such as the National Mental Health Policy of India (NMHP) launched in India in 2014 with a motto of *New Pathways New Hope* has introduced measures of improving the mental 'wellbeing' of the people by targeting their socio-economic status and providing them more amenities. The mental health measures conform to the macro-economic development of the country (Agarwal et al; 2004, p. 52). However, the governmentality (a rational perspective of the government and its practices) (Kerr, 1999) of these policy measures often gets unnoticed and consequently remains unquestioned by the public.

The strategies adopted by countries such as the USA and the UK to tackle mental health difficulties induce a connotation of 'holistic' development of an individual intertwined with economic growth at both micro and macro levels (Gunnell, 2020; Purtle et al., 2020). With the introduction of one of the UK's policy documents, No Health Without Mental Health (NHWMH) in 2012, the normalization of mental 'wellbeing' witnessed a new high where it stood as crucial as the physical health of the individuals or service users. This strategical perspective gradually started reflecting in non-westernized cultural heavy countries such as India and China (Kallivayalil, 2004) as the influx of globalization proliferated in South-Asian countries (Bhat & Rather, 2012). However, these countries faced an impediment in the replication of "westernized" policies when contested with the paternalistic cultural ideology and a relatively 'custodial' approach to the mental health framework. Nonetheless, it just became a matter of policies to focus on the 'rural' population as it probably seemed an easier route for the government to craft policies with an intent to fulfil the 'less privileged' families in India. This fulfilment was done through socio-economic upliftment and emphasizing the overall

development of the country (which in a way is the aim of any policy, in general). A study conducted by Jena and colleagues (2020) on 395 'rural' participants in India revealed that one-third of the participants had poor mental health and only 10% of them sought mental health treatment. This treatment gap in the study was addressed by inadequate knowledge and poor accessibility of mental health services (Jena et al., 2020).

Mental wellbeing and Recovery Mechanism

Governmentality On 'Recovery'

Whilst the adaptation of these policies, a particular perspective that further built the narrative of mental wellbeing was the 'recovery' discourse. The concept of 'recovery' however has been subjected to interpretations by policymakers (Jacobson, 2004). The validation and acceptance of a healthcare policy inherently depend on the efficacy and implementation of the 'treatment mechanism' suggested by policies over the years and the subsequent impression of the public towards that treatment mechanism. From 'recovering/curing' from a mental illness to a 'meaningful and creative way' to work on one's complete self, the treatment paradigm has seen a major discursive shift in the past few decades (Bonney & Stickley, 2008; Leamy et al., 2011). This encapsulates the 'recovery' discourse. This discourse is heavily built on the cultural ideology (Bhat & Rather, 2012) regardless of the geographical location. On a subliminal level, it portrays the incorporation of a 'thoughtful' and an 'improved' treatment mechanism for the population but underneath it might produce different meanings and attain a 'material reality'. This, material reality, has proven to be crucial to 'shape up' a country's governmentality and policy proposals. However, the overall efficacy and the perception of different stakeholders involved in the recovery discourse also stands crucial to influence the scope of mental health treatments, especially for the 'less accessible' populations. In the case of India, the 'less privileged' aligns with the 'less accessible' population, which is addressed in one of the policy segments in NMHP (2014). Whereas in NHWMH (2012), the construct of 'accessibility' of treatments encountered a barrier; the stigma and discrimination experienced by the 'socially

excluded' population to have equal accessibility as other communities. Thus, promoting measures that are 'socially inclusive' in nature has been one of the core objectives of the UK's mental health policies (Davies, 2005).

This paradigm of 'social inclusion' has apparently coupled with the 'recovery' discourse for service users (Bonney & Stickley, 2008) which has collectively given a significant contribution to the success of the 'service user movement', a movement where service users demanded more involvement towards policy framing and participation in the designing of psychological interventions (Chassot & Mendes, 2014). The recovery discourse prevailing in the UK has also led to the reinforcement of the service-user movement and has invoked a sense of 'individualism', 'self-care', and 'self-management' lifestyles (Chassot & Mendes, 2014). Contrary to this, NMHP (2014) has espoused a 'collectivistic' ideological framework. The stigmatization around mental health treatment has created a dependent environment for the people having mental health difficulties on their families/primary carers. Moreover, a blinded faith in religious healers by the families to treat mental illnesses has reinforced a conservative ideology among the Indian population paralyzing the 'technical' development of mental health interventions (Mills & Hilberg, 2018). The measures to challenge this ideology have been addressed in NWHP (2014). However, it is important to further investigate this conservative ideology and explore the nuances of the debilitating cycle of 'pathologizing' the mental 'wellbeing' discourse by the authoritative advocates of mental welfare.

Recovery Mechanism and Power Control

In addition to this, the debate between 'individualism' and 'collectivism' has propagated a political framework dedicated to neoliberalism (a doctrine that promotes decentralization of services and individual self-reliance) (Esposito & Perez, 2014) and the redistribution of power control among the various stakeholders/advocates of mental healthcare policies. This neo-liberalistic ideology has evolved in the UK policies since the 1970s as a response to economic recession (Ramon, 2008) to come across as a dominant perspective that implicitly controls the

political behaviour of the public and governs the discourse of mental healthcare policies. Conversely, the notion of 'collectivism' in India could be attributed to the socio-democratic/post communistic paradigm where the state/professionals/families possess an uncontested authority to take decisions on behalf of the person who needs mental health support. There is an exigency to question the impediment of individualism and to what extent this post communistic has influenced the governmentality of the different stakeholders.

Mental wellbeing, from an ideal perspective, should reflect an essence of individualism that eventually perpetuates into community development, but apparently, has restrained its narrative to political and cultural underpinnings (Bacchi & Eveline, 2010). The way in which the issues of unemployment, poverty, social exclusion, stigma, and a multitude of 'recovery' perceptions have 'shaped up' as potential problems in recent mental health policies can be better understood by analyzing the ontology of these 'pre-existing' problems which do prevail in the social reality waiting to be solved (Lancaster et al., 2015). The power struggle among all these disciplines has made the mental healthcare system fragmented and in reality, hasn't contributed much to the overall wellbeing of the public. However, in an attempt to solve the subliminal problems of mental health that has cropped up with time, crucial aspects such as the bidirectionality of policy and public behaviour get unnoticed and hence these deep-seated issues of mental 'wellbeing' remains a conundrum to all the stakeholders including the policymakers.

Research Question

Hence, this research project directs to explore what comprises the 'social reality' of mental 'wellbeing', Using Bacchi's (2009) post-structuralist methodology, the two official policy documents: NMHP (2014) of India and UK's NHWMH (2012) will be analyzed. The aim of the project is to identify those "deep-seated" cultural logics and assumptions (Bacchi, 2009) that conceptualizes and sustains the contemporary prevailing notion of mental 'wellbeing' through the linguistics of these policies. Furthermore, the project will delve into addressing the problems that are silenced underneath these policies and how the evolving meanings of mental 'wellbeing'

and the recovery ‘discourse’ have induced a neo liberalistic political framework. Carol Bacchi’s ‘problem representation’ approach (Bacchi, 2012) addresses the presuppositions and deep-seated conceptual logics which implicitly control the narrative of policymaking and public discourse (Bacchi, 2000).

Methods

Ethics Information

This research project does not require approval from the ethics department. The aim of the research is to compare two government policy documents and these documents are available in the public domain. The documents could be used to conduct analysis without any censorship or objection from any authority.

Hence, upon confirmation by the ethics team, the research project is independent of ethics approval.

Theoretical Framework

Policy as Discourse

Policy-as-discourse (PAD), a concept initiated to look beyond the literal meaning of a 'policy' primarily as a 'measure', it's purpose to solve 'problems' and accept it as an 'objective truth' (Bacchi, 2000). The premise underpinning the PAD approach tends to focus on criticizing the government's intent to 'bring out' and 'solve' the supposed problems through policy proposals and elucidating the notion that problems are rather 'produced' and 'shaped up' in policies (Bacchi, 2000). So far, policies have been analyzed from a relatively myopic perspective where the analysis began with accepting the policies as the "undisputed taken-for-granted" truth (Nair and Howlett, 2017). Bacchi's 'What's the problem represented to be?' (WPR) approach prompts us to think about the task of policy analysis in a wider political context (Bacchi, 2009). The WPR approach, inspired by feminist and post-structuralist disciplines (Archibald, 2019), aims to facilitate a critical interrogation of policies and programs that are designed to scrutinize the policy. The objective of policy is to not 'solve' rather 'produce' or 'discover' problems; problems that stand relevant to a specific time or circumstance (Bacchi, 2009). Historically, the reason for designing a 'policy analysis' was the severe dearth of theoretical underpinnings and limited interpretive knowledge in public policy research analysis especially in the field of mental health (Browne et al., 2018). Bacchi's (2009) WPR approach challenged the 'surface-level'

interpretation of ‘problems’ and the idea of framing ‘solutions’ in the form of policy measures. Bacchi emphasized incorporating this approach into policymaking and further substantiating the approach to delve into the cultural, political, economic, and social contexts behind the policy proposal (Spratt, 2017, p. 12).

According to Browne and colleagues (2018), the orientation of policy analysis can be categorized into Traditional, Mainstream, and Interpretive approaches. While the traditional and mainstream orientations dealt with the outcome and interaction-based approaches respectively, the ‘Interpretive’ orientation entailed ‘problem representation’ or ‘problematization’ (Browne et al., 2018). Bacchi tapped onto this terminology and explored its epistemological assumptions and the process of knowledge formation (Bacchi 2000). Problematization essentially comprises a two-phase process and defines an ontological and epistemological position from a critically discursive standpoint. The first phase focuses on analyzing “how and why certain entities such as behaviour, or a social practice become a problem”. The second phase explains “how these problems are shaped as objects for thought” (Bacchi, 2012). For example, as Foucault’s elaborates on his “history of madness” (Foucault & Khalfa, 2009) stating how problematization comes into effect by questioning, analyzing, classifying, and regulating different aspects of “madness” from various discourses and inducing a constructivist version of the object (in this case, “madness”) to produce a ‘social reality’ (Bacchi, 2012).

Considered as a relatively novel method of thinking and an interpretive method of analyzing policy, Bacchi (2009) reinforced the notion of infusing problematization as a way to ‘critique’ policy proposals. The purpose was to reveal those underlying assumptions which otherwise posed as the ‘uncontested obvious truth’. The critiquing entailed the 'knowledge formation’ based on the social reality, how people live their lives, how the functioning of a collective society shape-up the policies and vice-versa. It should however not be misinterpreted as a way of scrutinizing everything that the policy implies. Rather, it is a way to broaden our understanding of the influence of various discourses on constructing a material reality and exploring the “implicit system in which we find ourselves” (Bacchi, 2012). However, central to

the approach of PAD is the proposition that problems 'represented' in a policy are "endogenous" rather than "exogenous" (Bacchi, 2009) implying that 'problems' are produced within the policy processes and not existing outside of it. The problem representation is impacted by the governance and consequently regulates the public behaviour through the policy discourse. Bacchi reinforces the notion by probing the combined impact of multiple discourses and critically examining the policies through discursive practices (Lancaster et al., 2015).

Discursive Practice and Problematization

According to Fairclough, Discursive Practice comprises the "production, distribution, and consumption of texts" (Bacchi & Bonham, 2014). However, a multitude of concepts of discourse has developed from a post-structuralist and social-constructionist perspective by Freire, Foucault, and other philosophers (Bacchi, 2012) who primarily purported that language/discourse use is not limited to linguistic practices but possesses an interpretive and symbolic paradigm (Goodwin, 2011). Time and again, abstract concepts such as "sexuality", "madness", "feminism", etc. (Bacchi, 2012) have been subjected to public criticism and scrutiny. This gradually gave rise to the paradigm of 'social truth' behind these concepts. This paradigm further substantiated into exploring discourses (an entity that governs a social setup through thoughts, behaviour, and practices) and subsequently building up a 'material reality' that is dominated by questions such as how the current understanding of these concepts came into place, what were the cultural biases underlying these abstract concepts in the contemporary world, etc. Discourse, therefore, can be said to exert and regulate power dynamics because it institutionalizes the ways of talking, thinking, and behaving (Jäger, & Maier, 2009).

The journey of a 'discourse' from identifying the objective truth to transitioning into a subjective interrogation gave rise to the importance of discourse analysis. (Bacchi 2009). Hence, with an aim to delve deep into 'critical realism', Foucault's Critical Discourse Analysis (CDA) has subsequently emerged from a critical standpoint and has been influenced by a socio-political approach where the core focus comes upon addressing "pressing social issues" (van Dijk, 1993)

and questioning those underlying presuppositions that were otherwise normalized within existing discourses (Bacchi, 2009). A discursive approach to policy analysis construes that *"public policy is not just merely expressed in words, but literally 'constructed through the language(s) in which it is described."* (Fischer, 2003, p. 43). Overall, CDA aims to deliberately seek the propagation of problematic ideologies, discover the power relations at play governing policy framing, and reveal inconsistencies and contradictions through policy linguistics (Spratt, 2017, p. 19).

Analytical Framework

Bacchi's (2009) WPR methodology comprises six questions, which have a distinctive structure to their answers but are inherently related to elucidating a common theme. These are mentioned below:

Table 1

Bacchi's (2009, p. 2) 'What's the problem represented to be?' approach to policy analysis.

(1)	What's the 'problem' represented to be in a specific policy or policy proposal?
(2)	What presuppositions or assumptions underpin this representation of the 'problem'?
(3)	How has this representation of the 'problem' come about?
(4)	What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
(5)	What effects are produced by this representation of the 'problem'?
(6)	How/where has this representation of the 'problem' been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?

The WPR approach broadens Foucault's agenda. Using Bacchi's WPR methodology to address the 'social' world of mental 'wellbeing', this analysis focuses on answering Bacchi's (1), (2), (3), (4), and (5) as mentioned extensively in *Analyzing Policy: What's the Problem Represented to be?* (Bacchi, 2009). The policy measures will be traced back to reveal how the prevailing perception of mental 'wellbeing' is problematized and subsequently determines the 'recovery' discourse. The cultural and stigmatizing underpinnings of the recovery discourse try to impart a social reality to the political framework which is implicitly regulating the public's behaviour towards mental 'wellbeing'.

Procedure

The analysis began with an extensive study on Bacchi's (2009) WPR methodology and how it has evolved the study of policy discourse. As a first step, both the policy documents under analysis were read briefly. Upon the first read, the policy measures that were reiterating were highlighted and marked down. The highlighted measures were narrowed down to obtain various themes which were then developed into a problem 'representation'. Using examples from Bacchi's (2009) handbook, for example, highlighting the areas where the funds were getting allocated (Bacchi, 2009, p.4) or observing the problems that need 'fixing' in the policy document according to the government, etc. formed the basis of the problem 'representation'. For example, one of the objectives in NMHP (2014) stated as *"to increase access to mental health services for vulnerable groups including…educationally/socially/economically deprived sections"*, helped in narrowing down the scope of conceptualizing mental wellbeing as a deprived state of healthcare services caused by socio-economic factors. Parallelly, an extensive literature review was done on the mental health initiatives taken in the past few decades for both India and the UK. With the literature review, a substantial understanding of the historical context of the mental health policies and their subsequent implications were developed.

To identify the underlying assumptions as stated in question two, an understanding was formulated by minimizing the abstractness of the social construct of mental wellbeing to give

specific meanings (Bacchi, 2009, p.8). For example, the notion of 'recovery' in the mental 'wellbeing' conceptualization was largely observed from a 'governance' perspective and 'who stands where' in controlling the discourse of 'recovery' from the policy context. Post that, the different categories/dichotomies in the population that emerged with the problematization were considered to observe how they function to give specific meaning to the problem representation (Bacchi, 2009, p.9). For instance, the 'rural' and the 'non-rural' dichotomy simplified the conceptualization of mental 'wellbeing' in India and the analysis tended to focus on the 'rural' category.

For answering the third question, Foucault's genealogical theory (Bacchi, 2009, p. 10) was adopted to understand the epistemological context of the 'problems' considered in the analysis. This was done by identifying key historical decisions and identifying how the 'problems' have shaped up since then. The objective was to peek into and explore the power relations which are influenced through the problematization.

For the fourth question, the unproblematized notions or the silences were analyzed. This helped to curate another dimension of the 'problems' by limiting the discourse of problematization and observing what failed to be problematized (Bacchi, 2009, p. 12). This question is substantiated by the second question by focusing on where the simplification of the 'dichotomies' get distorted (Bacchi, 2009, p. 13).

Finally, the 'effects' of the problematization were analyzed in the fifth question. This was done by identifying three interlinked effects and critically 'weighing them up' – discursive effects, subjectification and lived effects – who is likely to get/not get benefited and what's likely to stay the same/change? (Bacchi, 2009, p. 15).

The overall aim of the WPR methodology is to trace out the 'social unconsciousness' and 'governmentality' underlying the problematization and explore the 'power control' through the policy discourse. However, to get acquainted with the themes that emerged in the analysis, it is important to understand the mental health policies in question.

Background of policies

The policies that were selected for the analysis were the National Mental Health Policy of India (NMHP; published in October 2014) with a motto of 'New Pathways New Hope' and No Health without Mental Health: A Cross-Government mental health outcome strategy for people of all ages (NHWMH; published in July 2012) of the UK. The policies were chosen by keeping in mind the political establishments and upheaval with respect to both countries.

Policy Document 1: National Mental Health Policy of India (NMHP, 2014)

NMHP (2014) was launched with an aim to reduce the treatment gap among vulnerable populations. The policy primarily reflects on providing mental health services integrated with the primary care approach model which has been re-strategized and redesigned over the years. This breakthrough decision as a mental health initiative, firstly came into effect in 1975, when the officials set up a community psychiatry unit as a step towards framing a general healthcare model aligned with tackling mental illness (Agarwal et al; 2004, p. 93) Ahead of that, the National Mental Health Program (NMHP) was launched in 1982, an initiative taken to institutionalize mental health services. The program focused on providing psychiatric facilities to specific sets of populations such as disaster-displaced, substance use, elderly, and suicidal individuals (Agarwal et al; 2004, p.30). However, due to its unidimensional approach and non-performing statistics, it was re-strategized in 2001 (Agarwal et al; 2004, p.34). Stigma and upheaval in the economic stability have been the dominant factors hindering the effective implementation of these policies (Khandelwal et al., 2004).

With the conception of NMHP (2014), the core objectives of NMHP (1982) were designed and adopted to curate a *"strategic, integrated and holistic policy with a pan India scaling up of existing Mental Health Program"* (NHMP, 2014). Moreover, in 2014, India witnessed a historic moment in their democratic election which brought the opposition party into the ruling position with immense faith and trust of the public. This professed a proclivity of the majority's expectations to anticipate remarkable changes in different sectors of the country.

Hence, it became important to interrogate the policymaking approach when the bi-directional relationship between public behaviour and policy implementation perpetually dominated the policy designing approach.

Policy Document 2: No Health without Mental Health (NHWMH, 2012)

This policy framework has been developed jointly by the Department of Health, the NHS Confederation's Mental Health Network, Mind, Rethink Mental Illness, Turning Point and Centre for Mental Health. NHWHM (2012) encompassed a wide range of views, from interested individuals and organizations, including mental health professionals, people who use mental health services, their families and caregivers. With six core objectives, NHWMH (2012) highlights focusing on "improving the quality status of on-going mental health framework. The policy was drafted under the Conservative and Liberal Democrat coalition government (2010-2015), a coalition government that was formed in over 70 years. This coalition, a post-election win was underpinned by ideological shifts coupled with the reactions towards the economic crisis in England and for the Liberals to prove their credibility by equally participating in the government (Evans 2017).

However, in the UK, the mental health policies have been supposedly constructed from 'social exclusion' (Bonney & Stickley, 2008). During its inception, the term 'social exclusion' broadly included, physically, mentally and 'socially maladjusted' individuals whose behaviour was not 'socially' acceptable (Silver, 1999, p. 532). In the UK, the debates around 'social exclusion' began in 1997 when the government announced to set up a Social Exclusion Unit (SEU). The agenda was to support the 'underclass' who suffered during the industrial retrenchment and failure of the welfare system during the 1980s (Davies, 2005). Soon, the SEU perpetuated to focus on the mental wellbeing of the socially excluded groups. However, social exclusion also happened to find its compositional elements in poverty, unemployment, inequality, and marginalization (Wright & Stickley, 2012). Hence, it became imperative for the government to introduce policies that entailed rightful access to mental healthcare for service

users belonging to socially excluded communities. The discursive shift in the ‘policy designing’ from economic upheaval (during the 1980s) (Wright & Stickley, 2012) to social exclusion (during the 1990s) (Selwyn, 2002) and now tending towards a socio-economic directive (Head & Bond, 2018) has substantiated a holistic development of service users in terms of providing equal access to mental healthcare to all communities and promoting self-management initiatives (Cummins, 2018) in NHWMH (2012).

Results

By applying Bacchi's (2009) WPR approach to identify problematization, explore the presuppositions underneath, and decode the silences and problematization effect, three themes have emerged as a result: (1) Conceptualizing mental 'wellbeing': 'Deprivation' vs 'Exclusion'; (2) Recovery discourse: 'Curative/Pathological' vs 'Self-Management/Personalized'; and (3) Political framework of mental wellbeing: 'Neo-liberalism' vs 'Socio-democratic' paradigms.

The first and second theme focuses on Bacchi's (2009) first, second, third, fourth and fifth questions. The third theme focuses on the second, third, and fourth questions.

Conceptualizing mental 'wellbeing': 'Deprivation' vs 'Exclusion'

In NMHP (2014), mental 'wellbeing' is essentially conceived as a "*holistic development*" (p.5) of a *"person with mental health problems*" (p. 8). It is elucidated in terms of an individual's physical, mental, and social optimal capacity and utilizing it to cope with stress, be productive and "*able to make a positive contribution to the community*" (p. i). Hence, the concept of mental 'wellbeing' is problematized as a dearth of an optimal status of mental 'wellbeing'. This dearth is addressed in NMHP (2014) by bringing up *"people with mental health issues"* to an adequate living standard. To achieve this living standard, the government proposes two primary measures: (1) minimizing the economic deprivation among people and (2) making the accessibility of mental healthcare care *"universal"* (p. 5).

The ideology that underpins the problematization of 'deprivation-induced-distress' is the predominant economic discourse that has defined the state of the country ever since the post-independence era. Considering a large chunk of people still living under poverty, an 'economic' discourse has governed the public behaviour in which being financially stable has been the priority element for sustenance and all other concerns including mental 'wellbeing' come secondary. NMHP (2014) has tried to ameliorate this ideology by rationalizing it as a social incentive by stating that *"spending on health by the government is not expenditure but a social*

investment and a social right" (p.9). However, an implication of minimizing the economic deprivation could be to strengthen the 'cognitive/social intelligence' of the people with mental health issues and their overall socio-economic status by making them 'employment ready'. NMHP (2014) has addressed this as: *"Facilitate education for person(s) with mental health problems to improve their employability"* (p.15). This ideological framework has a perpetuating effect on strengthening the political portfolio of the government and in a way, influences the 'governmentality' of other health-related policies and service design.

The problematization, in this context, targets the 'rural' population where the government thinks that the people have limited "access" to mental healthcare and the stigma towards mental 'wellbeing' is immensely prevalent. A focus on improving the living standards by making the access "universal" highlights the inadequacy of knowledge and awareness of mental 'wellbeing'. This inadequacy is attributed to the deeply engrained cultural discourse where mental 'wellbeing' is even merely a concept, in fact, is restrained to be 'internalized' by the people with mental health problems. Due to this, people seem to adhere to the ubiquitous economic discourse which has implicitly over-shadowed the concept of 'positive psychology' and looking at mental 'wellbeing' from a 'pathologizing' perspective. An implication of this 'inadequate knowledge' is addressed in NMHP (2014) as: *"This lack of knowledge of mental health and illness is often accompanied by fear and hostility towards those with mental health problems, due to which such person face exclusion from society"* (p. 6).

With NHWMH (2012), the concept of mental 'wellbeing' is primarily defined in terms of broadening its 'outreach' and 'accessibility' to the service users which imparts an optimistic tone to its objectives by stating that *"more people will have a positive experience of care and support* and *fewer people will suffer avoidable harm"* (p. 8). It implicitly states that a foundational work towards mental health support and wellbeing has been a success so far and now the policy is motivated to make a discursive shift in terms of equating mental health with physical health and 'normalize' mental wellbeing as it mentions *"putting mental health and wellbeing at the heart of the new public health system"* (p. 8). The deep-seated conceptual logic underpinning the

'normalization' of mental wellbeing and putting at par with 'physical health' is the notion of poor mental health leading to mental and physical illness and disability. The proposition that *"mental health is the single largest cause of disability in the UK"* in NHWMH (2012) was needed to address how mental disability is impacting the overall life of an individual.

Furthermore, in NHWMH (2012), mental 'wellbeing' has been problematized as a question of "social inclusivity" with an objective of *"reducing mental health stigma and tackling discrimination"* (p. 20). The presupposition underpinning this problem definition is the 'social exclusion' discourse that has guided the course of policies ever since the formation of Social Exclusion Unit (SEU) in the 1990s. The aim of SEU was to protect the rights of socially 'excluded' communities in terms of accessing mental health services without any stigma or discrimination. The exigency of the SEU came into notice when the country witnessed a grave form of 'stigmatization'. Service-users in the UK, consequently, dealt with stigma in two folds: one was the social stigma – imposed by the public and the other was self-stigma – an internalized mentality to feel put down by society which in turn, has direct causation on poor mental health. With the introduction of the *Time to Change Campaign* (p. 24) in NHWMH (2012), the policymakers intended to facilitate the professionals and staff to *"raise the profile of mental health across the authority and address stigma among staff"* (p. 35) with more sensitivity. Hence, this problematization emphasizes on stigma prevailing among the service-users and the healthcare professionals.

Conversely, NMHP (2014) serves a slightly antagonizing tone to the policy framework where the policymakers want to have more *"discussion in public space on rights of persons with mental health problems*" revealing that no substantial work has been done yet and the government is in the process of initiating a public dialogue and is stepping onto creating awareness. The 'rural' population is often labelled as 'vulnerable' in this context and the *"lack of awareness of nature and prevalence of mental health problems"* (p.6) paralyzes the notion of 'incompetent government efforts' and compels the 'vulnerable' population to elevate their educational and economic status to be able to employment fit and eventually progressing

towards becoming a country's asset. This underlying assumption has a subjectification effect (Bacchi, 2009, p. 16) on the 'incompetent population' which has labelled the individuals seeking mental or psychological help as 'patients'. Contrary to that, NHWMH (2012) has reflected a relatively "constructive" approach to developing the perception of mental 'wellbeing' as a *"shared human process"* rather than an illness. These measures, however, imply the service users as 'rational agents' who, in the policy, are suggested to be as active as the government in coming forward and challenge the stigmatizing behaviour.

However, a perpetuating after-effect that gets silenced in this problematization is that, in India, individuals might feel incapacitated to fit themselves into the 'labour market' thereby exacerbating their mental health and incorporating a vicious cycle between gaining economic status and mental health difficulties. This problematization of a lack of mental 'wellbeing' as 'deprivation of amenities' has impinged into creating demarcations between the 'rural' and 'urban' population in a sly fashion through government policies. Moreover, ignorance and suboptimal adaptation of the "westernized" approach of mental 'wellbeing' has led to the 'pathologization' of mental 'wellbeing' thereby paralyzing the notion of 'positive psychology'.

Drawing parallels with the UK, India is relatively in the initial stages to provide equal 'access' to quality mental healthcare to the 'vulnerable' groups and implying that the accessibility has been suboptimal majorly due to the centralization of mental healthcare services. The marginalized and stigmatized landscape has reinforced the notion of observing mental healthcare from a 'deprivation' perspective in India and from 'social-exclusion' perspective in the UK. To understand a wholesome perspective of the discourse of mental 'wellbeing', it is imperative to get familiar with the process of how people with mental health problems perceive the suggested treatments and interventions which is stated here as the 'recovery' discourse and highlighted in the next section.

Recovery discourse: 'Pathological' vs 'Personalized'

Recovery, as an intricate and widely subjective construct, has its roots in diverse threads to sustain and promote mental wellbeing in the public domain including person-centred interventions approach, social inclusion, service user and carer responsibilities, power control, and self-management approaches (Davidson, 2005). Extending the conceptualization, the 'recovery' discourse stands crucial in materializing the past and ongoing perception of mental 'wellbeing' and aids in seeing a visible 'change' in the status of mental health of individuals. From a cross-national analysis standpoint, it highlights the shaping up of 'governmentality' of the recovery discourse and witnessing how the responsibility of recovery or treatment is manifested among various stakeholders.

NMHP (2014) posits the 'recovery' discourse of mental 'wellbeing' as a predominantly 'reactive' approach catering to the *"primary health care approach"* (p. 3). It essentially underpins a conflicting combination of a biomedical and cultural framework on how 'recovery' has been problematized as 'custodial' or 'rehabilitative' in the cases of severe mental health disorders otherwise is subjected to conservative ideology of religious healing and home-grown measures undertaken by familial dominance (Agarwal et al; 2004). The genealogy that supports this problematization is that India has observed a custodial to a curative shift in the 'recovery' mechanism since the implementation of the Mental Health Act (Ministry of Law and Justice, 1987). The pre-and post-colonialist era has witnessed a rehabilitation-heavy treatment approach where 'patients' were confined to asylums that reinforced the 'reactive' approach to cure mental illness and subsequently 'pathologizing' the discourse of mental healthcare. For example, in reference to the "custodial-curative" shift, the decriminalizing of suicide and attempted suicide in 2017 (Mental Health Act, 2017) has been a significant milestone where the government finally acknowledged that it is the government's responsibility to offer optimal care to those who attempted to commit suicide. NMHP (2014) also adheres to this governmentality by addressing

"stigma, discrimination and exclusion" around *"implementing suicide reduction programmes"* (p.15).

NMHP (2014) uncovers that the objective "taken-for-granted" truth behind the responsibility of 'recovery' on caregivers could be the familial dominance where the primary caregiver/family is the sole decision-maker for the affected individual. The family or the caregiver usually represents the person with psychiatric care, taking them to religious/spiritual healers or merely just showing ignorance (at times). This presupposition has discursively accounted for a 'limited' perspective of recovery mechanism which could be substantiated by effects such as 'internalizing' and rejecting having a mental illness by individuals due to fear of societal stigma, over-faith in religious healers, and lack of affordability, accessibility, and availability of mental health services. The genealogical evidence enabling this presupposition could potentially be the paternalistic attitude of Indian families and their dominance in handling situations concerning any kind of social stigma, which is addressed in NMHP (2014) as *"services should be family-centric to address needs of persons with mental health problems across life-span"* (p.16). Hence, the 'recovery' discourse, in this context, places the *"person with mental health problems"* as a 'burdensome' entity on its family as the family/caregiver solely represents the individual to seek mental health support.

However, being governed by a biomedical/cultural discourse, the advocacy of mental healthcare services and their implementation in India often remains fragmented. Different stakeholders of mental welfare such as psychiatrists, psychologists, community leaders, spiritual leaders, family representatives, etc. cause a discursive effect on the recovery discourse by bringing out varied definitions of mental health and treatment mechanism. Hence, NMHP (2014) makes a proposition to *"motivate and engage stakeholders from relevant sectors, in particular persons with mental health problems, care-givers and family-members, civil society leaders and those with management and strategic implementation expertise in the development, implementation and evaluation of mental health policies, laws and services, through a formal*

mechanism" (p.13). Differences in their opinions often create a spectrum of an ambiguous 'public dialogue' of recovery which could probably baffle the individual to seek appropriate treatment course. This ambiguity could potentially imply that the blame to provide a 'holistic treatment' is no longer on the state. Indian biomedical and cultural discourse posits that the authority to choose the interventions (be it biomedical or spiritual) lies with the caregiver, professionals, and doctors. Hence, it elevates the governmentality of biomedical and cultural discourse and limits the mental 'wellbeing' to a collectivistic perspective. This diminishes the propagation of 'psychological' discourse especially in the 'rural' population (where the psychological discourse of mental wellbeing is still an undermined concept).

The UK, on the other hand, has witnessed a custodial to a curative to an 'introspective' shift in its recovery paradigm. NHWMH (2012) looks upon 'recovery' as a spectrum where service-users deal with mental health issues at different intensities and frequencies. A notion of 'personalized recovery' has emerged from the policy as mental 'wellbeing' and is partly defined as a 'self-management' form of treatment. It has emphasized on social care elements such as *"Recovery college"* (p.20) with an aim to educate service-users about positive 'wellbeing' and support them in their *"personal recovery journeys"*.

One of NHWMH (2012) objectives, *"No decision about me without me"* (p. 5) reveals an 'individualistic' and 'self-dependent' discourse when concerned with the responsibility of the service user's recovery. As a result, the needs of the service users are better understood, and assistance is provided in a more personalized way. NHWMH (2012) proclivity towards 'self-management' and 'self-introspective' approach is also influential in implicitly directing the narrative of 'recovery' towards 'social inclusivity' and gaining 'equity in accessing' mental health services. A striking example of this narrative was the emergence of 'service-user' movement during the 1990s where the service-users did not believe in conforming to the intervention methods imposed by the state and demanded service-user led treatment mechanisms. Hence, NHWMH (2012) has seemed to incorporate an equal focus on a spectrum

of mental health crises as it states that "*health and care services focus on recovery, rehabilitation, and personalization"* (p.11). Moreover, it corroborates the notion of 'positive psychology' by asking "*people to build lives for themselves outside of mental health services with an emphasis on hope, control and opportunity"* (p. 18). The increased demand for 'personalized interventions' and 'positive psychology' reflects on the neo liberalistic perspective of the policy.

Amidst the journey of recovery discourse, one of the arguments that are left unproblematized is analyzing the efficacy of 'clinical' recovery vs 'personal' recovery under the 'recovery' paradigm. These two categories ideally should be a unified approach to substantiate mental 'wellbeing' but apparently, the 'personal' recovery comes across as a probable 'consequence' of 'clinical' recovery. The presupposition underpinning this dichotomy goes deep down in identifying how a clinical course of recovery is being carried by out practitioners, how they implicitly perceive the treatment course as 'ambiguous' and 'illusionistic' and finally, how the service-users get inherently impacted to divert to a 'personal recovery' approach. From a policy framing context, the clinical interventions thrive in policy documents but are hardly scrutinized from a humanized perspective. Though there is a focus on personal recovery in terms of service -users taking ownership of their treatment but it is important to question the circumstances that have led to a dedicated focus on 'personal' recovery.

However, both the policy documents have directed the recovery mechanism towards "*evidence-based treatments"* (NMPH, 2014, p. 4; NHWMH, 2012, p. 10) inferring to the "technical" development of the recovery paradigm. This development has, however, induced polarizing meanings in both countries. Conversely to a well-equipped and a competent approach of NHWMH (2012), NMHP (2014), the vague description around the technical development presented as *"decision making from findings from research, practice-based evidence and feedback from clients"* has not seen a substantial success. This could be attributed to the conflict

between the technical-cultural ideology in India, leading to a fragmented 'clinical' framework of mental health.

Political framework of mental 'wellbeing': Neo-liberalism vs socio-democratic paradigms

To identify what political framework justifies the conceptualization of mental 'wellbeing' can be a contesting debate between a "neo-liberalistic V/S socio-democratic" approach. Apparently, both countries policies' do not strictly adhere to a single discipline rather produce segments that make the mental healthcare system oscillate between these two mentioned approaches.

The objectives of NMHP (2014) essentially states that *"increase access to mental healthcare services for vulnerable groups, to enhance availability and equitable distribution of skilled human resources for mental health and to progressively enhance financial allocation and improve utilization for mental health promotion and care"* (p.6). These objectives reflect on the post communistic/socio-democratic ethos of the country where the state oversees the entire network of mental healthcare, and the services are centralized in developed cities with limited to no access to these services by 'rural' population. The socio-democratic paradigm is attributed to the conceptualization of mental 'wellbeing' and 'recovery' discourse as a 'state-controlled pathologization' and socio-economic upliftment of ill mental health individuals. However, being impacted by globalization, NMHP (2014) has shown a tender proclivity towards a neo-liberalistic approach where it aims for "*inter-sectoral collaboration"* (p.10) and 'deinstitutionalization' of mental healthcare services by *"developing technical capacity to centre, state, district, and local levels to plan, monitor and implementation of mental health policies, laws, and programs"* (p.13). Consequently, this has allowed a dependency on communities and non-governmental service providers to keep a check on persons with mental health problems. Hence, the combined effect of this varying landscape could be perceived as partly neo-liberalistic and partly socio democratic. This combined effect also potentially accounts for the half-baked implementation of the policy where there is a paradoxical narrative of the government wanting to shift quality resources to 'rural' areas and make them more

accessible and simultaneously, standing neutral and ambiguous about the allocation of funds and implicitly asks the resources hired to take ownership of their actions: *"Service and service providers are ultimately accountable to person(s) with mental illness and their care-givers*" (p.5). The dynamics of mental healthcare have observed a paradigm shift from custodial (rehabilitation) to a curative (primary health services and interventions) approach and now NMHP (2014) is stepping towards trying to widen the 'curative' approach to less-accessible areas. However, despite progressing towards less-accessible areas, the government is still reluctant to operate the *"community and social care development"* with a generous financial backing which reinforces the socio-democratic paradigm by stating that:

"It is also important to keep in mind that additional funding may not be required for many social sector programs." (p.10)

The present healthcare system in India is inherently controlled by a powerful administration comprising of psychiatric institutions, which share a strong association with the political and academic institution of healthcare policies. Ideologically, the system is underpinned by the deep-seated prevailing culture of paternalism and dependence and attributed to the presupposition that people with mental health problems are incapable to make independent decisions, hence psychiatrists, psychologists and mental health practitioners 'need' to take care of them in a slightly paternalistic way. In fact, the service users and family organizations are bounded to conform to this traditional system, because they are possibly unaware of better alternatives or gain financially dependency on institutions lobbying for institutional care and the biomedical paradigm.

With a penetrating wave of neo-liberalism, NHWMH (2012) has been influential in implicitly promoting 'individualism' to facilitate the political framework of mental 'wellbeing'. Moreover, with the introduction of "service user-led course design", the mental healthcare mechanism in the UK also construes a connotation of individualized strategical perspective. The disparity between the government and service-users over possessing the ultimate decision

control on redesigning mental healthcare framework has witnessed a shift toward service-users and substantiated the reinforcement of the 'service-user movement'. Service users, traditionally, felt a compulsion to fit into a pre-defined state-dominated healthcare system and were labelled as 'trouble-makers and 'non-complaint' to the proposed treatments. This compulsion subsequently proved to be rather inefficacious, and service-users demanded the treatments to be more "personalized". It is interesting to note that the subjectivity of 'personalization' has broadened with time which has forced the policymakers to introduce 'recovery' measures in the direction of *"hope, control and opportunity"*. This might indicate that with future evolving definitions of personalization, there might be a possibility of 'over-emphasizing' and 'sensationalizing' individualism.

The resources (support staff and professionals) in NMHP (2014) are a significant constituent in reducing the treatment gap for these populations. However, these resources find it difficult to make the treatment more accessible. They tend to show unwillingness to move to relatively under-developed parts of the country as there is a lack of financial backing from the state. Hence, conforming to the economic discourse, the government does expect and promote the notion of *"community development*" but is rather reluctant to spend a generous budget allocation to the financial wellbeing of the mental healthcare professionals. The inevitable power struggles between the different actors (service users, healthcare professionals, leaders, and the state) responding to this varying mental health discourse formulate a rather complex system. Also, the tendency to develop and broaden services in a decentralizing way can end up again being a fragmented system resulting in a high level of conflict in the system.

NHWMH (2012) also vouches for "*involving local independent, voluntary, community organizations"* for promoting recovery (p. 25). With the establishment of the voluntary (not-for-profit) sector, there has been a shift in the political and economic discourse aiming towards 'decentralization'. Like India, the state was reluctant to provide limited to no funding to these voluntary sectors. In a sense, the UK healthcare system tended to espouse a sense of social

democracy as well. This inherent contradiction in ‘empowering’ the system is attributed to the dominance of a hybrid liberal collectivistic discourse of the UK coalition government which has managed to impose neoliberalism on the UK mental healthcare system while ensuring a high level of government control.

With a flooding course of urbanization and neoliberalism, the governance in both India and the UK has been trying to impose the commodification of the healthcare sector and imparting a social narrative to mental wellbeing similar to physical wellbeing, though not in an optimal way.

Discussion

Using Bacchi's WPR methodology, this research project focused on problematizing and differentiating the 'social reality' of mental 'wellbeing' between India and the UK through policy documents. To summarize, in India, the problematization revolved around the societal deprivation of amenities leading to a socio-economic narrative of the mental healthcare system for the 'rural' population. However, the construct of mental 'wellbeing' as such did not reflect anywhere in the policy rather was presented as a lack of it. The 'deprivation-induced-distress' essentially rose from the pre-dominant economic discourse where the majority of the population have been surviving below the poverty line. However, the policy's intention behind the macro-economic development could indicate a perpetuation of political dominance which is gained by supplying economic power to those 'less privileged' covered with a blanket of 'mental health policy measures'. This governmentality could further imply to debilitate the inadequacy of knowledge related to mental 'wellbeing' among people.

Moreover, the analysis was successful in the portrayal of the contested debate between cultural ideology (in this case religious-based) and biomedical approach. This conflict has created a conundrum both at the individual and community level to adapt to an optimal mental health framework, hence suppresses the psychological discourse. Given the diametrically opposite beliefs toward mental illnesses in India, it is understandable that the medical and nonmedical models are working in isolation and a constructive approach is needed to regulate an effective mental wellbeing discourse. This debilitating cycle of 'pathologizing' mental health caused due to conservative ideology is in alignment with the existing literature and gravely exacerbating the holistic concept of mental 'wellbeing'.

The analysis tapped onto the "westernized" influence of mental 'wellbeing' discourse on cultural heavy countries. However, upon analysis, the definition of a nation's status of mental 'wellbeing' (which was comprised of individual's sensibilities, environment, and culture as

stated in the Introduction) did not strictly adhere to the existing literature and is potentially getting redefined as the 'social reality' of mental 'wellbeing' dominated by a cultural ideology that further determines the person's awareness and the effectiveness of the environment/governance.

However, in the UK, the problematizations were seen as 'normalizing' mental health (putting at par with physical health) and a question of 'social inclusivity'. The economic and stigmatizing discourse underpinning this problematization can be effectively attributed to the formation of SEU Units and the service-user movement in the mental health paradigm. However, an over-emphasis on individualism and the dominance of neo-liberalistic ideology has collectively induced the notion of a lack of mental 'wellbeing' as a result of social and personal failures among the service-users. With globalization getting directly and profoundly impacted by neoliberalism, the promotion of mental health problems and their corresponding interventions can be anticipated to be positively impacted by deinstitutionalization of services along with an economic backing.

Furthermore, looking at the discursive shift in the recovery paradigm of both the countries, it seems like that there is an inherent competition between Indian and the UK to achieve a recovery paradigm where the government is not seen as directly responsible for the effective regulation of these policies and hence implicitly puts the onus of 'recovery' on mental health professionals and service users. In view of the neo liberalistic paradigm, the commodification and privatization of mental health should be treated as a potential concern and further analyzed under the scope of mental healthcare framework.

To stabilize the difference between the medical and non-medical paradigms, a hybrid model needs to be institutionalized that governs the mental healthcare framework in India similar to the hybrid collectivist approach conceived by the UK. The socio-democratic ethos of India has perpetuated a cycle of shifting blames towards taking the responsibility of regulating

an effective discourse of mental wellbeing. However, this tendency might continue to prevail unless the stigma is completely eradicated.

However, there were a few limitations associated with the analysis. Firstly, the selection of policies and the corresponding texts chosen was restricted to a particular time frame and analysis was limited to a few sub-sections. This was done to evaluate the discourse for a specific time frame and the criterion for selecting the sub-sections was to later get formulated as potential themes for the analysis. Moreover, the analysis intended to focus on a targeted set of populations in order to narrow down the scope of problematization. Furthermore, while delving deep into the underlying assumptions, the author has moderately adopted nuances of critical reflexivity of the WPR approach (Bletsas & Beasley, 2012) which might perpetuate a biased perspective in the analysis. However, some aspects of the problematization were left unexplored (arguments that were 'silenced' under the scope of problematization). Hence, future research can be focused on those silenced aspects, for example, proposals regarding mental health promotion in different settings and how the recovery or clinical interventions are contributing to the recovery discourse, etc. Moreover, India is now witnessing a wave of neoliberalism in the urban population (which is not problematized and could be investigated as future research) where private psychiatric services have taken a front lead and are trying to fill up the vacuum that the government policies could not cater to (Khandelwal et al., 2004). This could potentially reinforce the government's intention to keep their primary focus on the 'rural' population intact whilst framing policies.

Conclusion

With varying conceptualizations, it can be proposed that ‘stigma’ and ‘economy’ are driving the narrative of mental ‘wellbeing’ at the root level. The stigma is deeply engrained in the paternalistic ideology but with the provision of equity to different stakeholders in terms of accountability and facilities, the constitution of an optimal mental healthcare framework can be envisaged. A foreseeable consequence of the socio-democratic approach is that in an effort to sustain political dominance and favouring vulnerable groups through policies, the policies seem to get adulterated (Bonney & Stickley, 2008). This could make the mental healthcare system fragmented and a potential conflict could emerge against obtaining an effective leadership on mental health framework.

Mental wellbeing, like any other social construct, should be subjected to constant arguments and scrutiny in the public eye and with more awareness, the problematizations underlying the policy measures will get a chance to surface and curate a holistic discourse of mental ‘wellbeing’. With these changing definitions and problematizations, a focus on how we manifest the self-stigma and perceive any social construct concerning mental wellbeing directs the route of governmentality and henceforth any upcoming policy proposals.

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Appendix A - Ethics Information

This research project does not require approval from the ethics department. The aim of the research is to compare two government policy documents and these documents are available in the public domain. The documents could be used to conduct analysis without any censorship or objection from any authority.

Hence, upon confirmation by the ethics team, the research project is independent of ethics approval.

Appendix B - Studying WPR methodology

Bacchi's approach of 'problematization' was comprised of six questions. Five of which were answered in the analysis. The procedure used to develop the understanding of Bacchi's WPR methodology was developed from the below keynotes and dissected in the following ways:

1. What's the 'problem' … represented to be in a specific policy or policies?

    - *What 'issue' is the policy trying to solve?*
    - *Looking at how and to what 'problems', the funds are being allocated.*
    - *What is the problem that is taken for granted or normalized?*
    - *Tracing back to the problem, considering the policy measures as the source*

2. What presuppositions and assumptions underlie this representation of the 'problem'?

    - *What are the modes of governance or 'governmentality'?*
    - *What is the conceptual logic underpinning the problem representation?*
    - *Identifying the Dichotomies/Binaries and to which side the problematization falls?*
    - *How social concepts are formed by minimizing the abstractness. What is the base/categories or labels given?*
    - *how the support the problematization/what discourse it follow. Is there a triangular relationship between discipline/sovereign/governmentality?*

3. How has this representation of the 'problem' come about?

    - *Identifying the genealogy of the problem.*
    - *Highlight the conditions that helped the 'problem' to shape up within the policy context.*
    - *What were the assumptions and dynamics of dominance that have gone down the history to shape up that reality?*
    - *Which power groups initiated and dominated the discourse?*
    - *Analyzing how surveys and census assigns categories to the public?*

4. What is left unproblematic in this problem representation?

    - *Policies are complex to derive out problematizations from them (which are often contradictory and proposes polarized perspectives).*
    - *There will always be some aspects that would be unaddressed because the analysis needs to be narrowed down and less abstract.*
    - *Where are the silences or what couldn't be problematized as a concept of mental wellbeing?*
    - *Can the 'problem' be thought about differently? – within the limited policy discourse*

5. What effects are produced by this representation of the 'problem'?

- *Identifying the three interlinked effects and critically weighing them up –*
    i. *discursive effects*
    ii. *subjectification*
    iii. *lived effects*
- *who is likely to get/not get benefited and what is likely to stay same/change?*
- *Who needs to be blamed for the problem represented to be?*
- *What is the perception of the targeted population about the one who is to blame?*

Appendix C - Selection of Texts and Themes Formulation

The selection of texts for the analysis was strategized in a way that the most reiterated subjects gets selected in order to develop a thorough understanding of discourse. The policies under analysis were National Mental Health Policy (2014) of India and No Health Without Mental Health (2012) of the UK. Below are the examples of few texts selection and how potential themes were developed from the texts:

National Mental Health Policy, India (2014)

Texts Selected	Potential Themes
The vision of the National Mental Health Policy is to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span, within a rights-based framework	- Holistic development - Promoting Destigmatization - Improving socio-economic status - Curative approach to mental wellbeing
Human rights and dignity of persons with mental health problems should be respected, protected and promoted. Mental health care should promote and protect the autonomy and liberty of person(s) with mental health problems.	Violation of rights in accessing mental healthcare
Government, opinion-makers, media and community leaders should encourage discussions for better understanding of the nature of mental health problems. There is a need for compassion and responsibility in our interaction with persons affected with mental health problems instead of stigmatizing such persons.	Aiming for inter-sectoral collaboration and distributing responsibility for promotion of mental health

No Health Without Mental Health, UK (2012)

Texts Selected	Potential Themes
The draft Mandate proposes that the NHS Commissioning Board develops a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health.	- Normalizing mental health - Positive psychology
Raise the profile of mental health and address stigma among staff. Inspire a culture where discrimination has no place, stigma is actively challenged, and your staff, customers and the local community can see you leading the way.	-Destigmatization -Improving quality of life/mental health framework
Health and care services focus on recovery, rehabilitation and personalization. Considering how service users' perceptions of recovery can be incorporated into all elements of clinical practice and working to ensure people have appropriate support and access to advice and information.	-Recovery discourse preventive/curative and personalized. -Individualism and promotion of positive psychology

Appendix D - Thematic map